

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01928

1952

PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Harre de Grace

c. LENGTH OF STAY IN 1b

over 2 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

550 Revolution Street

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Harford

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Harre de Grace

d. STREET ADDRESS

1550 Revolution St.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED

First

Middle

Last

(Type or print)

David

John

Bordley

4. DATE OF DEATH

Month

Day

Year

2

28

1961

5. SEX

male

6. COLOR OR RACE

negro

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

Sept. 7, 1908

9. AGE (In years last birthday)

52 yrs.

IF UNDER 1 YEAR

Months 5

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Contractor

11. BIRTHPLACE (County & State, or foreign country)

Newcastle, Delaware

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Bordley

14. MOTHER'S MAIDEN NAME

Roxie Rumsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no -

16. SOCIAL SECURITY NO.

222-03-3953

17. INFORMANT

Mrs. Ella M. Bordley, 550 Revolution St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Acute Fulminating Pneumonia

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Influenza & Bronchiolitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2/25, 1961 to 2/28, 1961, that (I) (we) last saw the deceased alive on 2/28, 1961, and that death occurred at noon, from the causes and on the date stated above.

22a. SIGNATURE

George T. Stansbury

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

3/2/61

22c. PHYSICIAN'S NAME (Type)

George T. Stansbury

22d. ADDRESS

569 Revolution St. Harre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3-4-61

23c. NAME OF CEMETERY OR CREMATORY

Berkley Cemetery

23d. LOCATION (City, town or county)

Marlington, Harford, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur J. Bullock, Harre de Grace, Md.

ADDRESS

25a. REC'D BY REGISTRAR

MAR 7 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1182

OFFICE OF THE

1955



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1953 CERTIFICATE OF DEATH

01929

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FOREST HILL			
c. LENGTH OF STAY IN 1b 2 DAYS				d. STREET ADDRESS ROCKS ROAD			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY ELIZABETH BROWNING				4. DATE OF DEATH FEB. 20 1961			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 29, 1912	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) Allegheny Co. N. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME AMBROSE PUGH				14. MOTHER'S MAIDEN NAME CORDELIA SARAH ROUPE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 220-07-5381		17. INFORMANT JOSEPH K. BROWNING FOREST HILL, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Metastasis from ca breast. DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) </div> <div style="width: 50%; text-align: right;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1955 to Feb. 20, 1961 , that (I) (we) last saw the deceased alive on Feb. 20, 1961 , and that death occurred at 1:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Wm. K. Brundel</i>				22b. DATE SIGNED		22c. NAME (Type) Wm. K. Brundel	
22d. ADDRESS				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 2/22/1961		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Garden		23d. LOCATION (City, town or county) (State) Bel Air Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles C. Furtz</i>				25a. REC'D BY REGISTRAR FEB 23 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hradek</i>	
ADDRESS Jarrettsville, Md.				DATE			

1952



10/10/52

10/10/52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
1954 CERTIFICATE OF DEATH 01930													
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Pa. b. COUNTY York								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Whiteford					c. LENGTH OF STAY IN lb 11 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Delta					d. STREET ADDRESS R.D.#1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) LAURENCE ELLSWORTH BUCHANAN					4. DATE OF DEATH First Middle Last Feb. 20, 19 61		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH June 2, 1895					9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor					10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (County & State, or foreign country) Whiteford, Md.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William G. Buchanan					14. MOTHER'S MAIDEN NAME Nellie Coleman								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI					16. SOCIAL SECURITY NO. 218-07-8073		17. INFORMANT Clifford Buchanan, Whiteford, Md.					Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cor Pulmonare (c) Chronic Emphysema causing the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1959 to Feb 20, 1961 , that (I) (we) last saw the deceased alive on Feb 19, 1961 , and that death occurred at M , from the causes and on the date stated above.													
22a. SIGNATURE Jonah A. Hunt					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/21/61				
22c. PHYSICIAN'S NAME (Type) Jonah A. Hunt					22d. ADDRESS Delta, Pa.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-24-1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion			23d. LOCATION (City, town or county) (State) Delta, York Co., Pa.					
24. FUNERAL DIRECTOR'S SIGNATURE John H. Haskins					ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR DATE FEB 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

1954



Chronic Bronchitis
For Diagnosis
Microscopic Findings

27 Feb 54

2/2/54

✓
Data . 10.

✓
Lorick A. Hunt
J. C. Hunt
Feb 17 61

Waterbury, Conn.

W. C. Hunt

2-24-61

W. C. Hunt

Chronic

1954

Waterbury, Conn.

W. C. Hunt

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any body is necropsied, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div>tem 18-61-288</div> <div>1955</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01931</div>																	
1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood c. LENGTH OF STAY IN lb 6 yrs., d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood d. STREET ADDRESS Emmorton e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last EDGAR L. CHAPPELL						4. DATE OF DEATH Month February Day 20 Year 19 61											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June, 12, 1912		9. AGE (In years last birthday) 48 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Auto				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.,							
13. FATHER'S NAME James Chappell						14. MOTHER'S MAIDEN NAME Linnie Cox											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 2756 230-05-7756		17. INFORMANT Address Mrs., Elza C. Chappell Edgewood, Maryland.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Gastric Contents due to Fatty Liver and Cirrhosis 5810 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State).									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Charles S. Petty</i> EXAMINER'S NAME (Type) Charles S. Petty, M.D.						DATE SIGNED 2/21/61											
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF Feb. 23, 1961		22c. NAME OF CEMETERY OR CREMATORY Vaughan-Gwynn F.H.,		22d. LOCATION (City, town, or country) (State) Galax Virginia									
23. FUNERAL DIRECTOR <i>Howard K. Brown Jr</i>						ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR FEB 24 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>							

MEDICAL CERTIFICATION

2

2

RECEIVED
JUN 1 1915

1915

DEPARTMENT OF STATE

Harford

Harford

Harford

Essexwood

Essexwood

6 yrs.

Essexwood

6 yrs.

1915

1915

1915

June 1, 1915

June 1, 1915

June 1, 1915

U.S.A.

U.S.A.

U.S.A.

U.S.A.

Lincoln Cox

James Chapman

1915

Essexwood, Maryland

Essexwood, Maryland

Essexwood, Maryland

Essexwood, Maryland

Essexwood, Maryland

1915

1915

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

1 #

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1956

01932

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u> <input checked="" type="checkbox"/>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampden</u> <u>D.O.A.</u>		c. LENGTH OF STAY IN 1b <u>07X2</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> <u>Rural</u>		d. STREET ADDRESS <u>07X2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Doit Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Lewis - Asa - Coulson</u>				4. DATE OF DEATH <u>February 22</u> 19 <u>61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/1912</u>	9. AGE (In years, last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wiley Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Eli Coulson</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Rambo</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-09-6911</u>		17. INFORMANT Address <u>North East Maryland</u> <u>Mrs. Alice Reed Coulson</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture cervical vertebra</u> <u>910-3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Steel beam dropped on head</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>↓</u>					
20c. TIME OF INJURY Month, Day, Year <u>11</u> a.m. <u>2-22-61</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wiley Constr. Co.</u>		20f. (City or town) (County) (State) <u>Port Deposit Cecil Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Ar</u> <u>nd</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD.</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-22-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Coler a Md.</u>	
23. FUNERAL DIRECTOR <u>Commonwealth E. Mc Miller</u>				24a. REC'D BY REGISTRAR <u>Rising Sun Md.</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

1912

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Duration of illness

8. Name of physician

9. Name of attending nurse

10. Name of undertaker

11. Name of funeral home

12. Name of cemetery

13. Name of funeral home

14. Name of cemetery

15. Name of funeral home

16. Name of cemetery

17. Name of funeral home

18. Name of cemetery

19. Name of funeral home

20. Name of cemetery

21. Name of funeral home

22. Name of cemetery

23. Name of funeral home

24. Name of cemetery

25. Name of funeral home

26. Name of cemetery

27. Name of funeral home

28. Name of cemetery

29. Name of funeral home

30. Name of cemetery

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1957

01933

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			c. LENGTH OF STAY IN lb <u>4 years</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Francis</u> Last <u>Cullum</u>			4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 5, 1874</u>		9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Norah Franklin Simpson</u>		
14. MOTHER'S MAIDEN NAME <u>Emma V. Levey</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>No</u>			17. INFORMANT <u>Harford Convalescent Home, Rt. #1, Bel Air, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO (c) <u>Chronic cardio-vascular disease</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>?</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Sept. 16, 1956</u> , to <u>February 14, 1961</u> , that I last saw the deceased alive on <u>Feb. 13, 1961</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Willard P. Hudson</u>			ADDRESS (Street, city or town, state) DATE SIGNED <u>Forest Hill, Md. February 14, 1961</u>		
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Darring - Aberdeen, Maryland</u>			
24a. REC'D BY REGISTRAR DATE <u>FEB 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1958
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>HAURC de Grace</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Perryville</i>	
c. LENGTH OF STAY IN 1b <i>14 days</i>		d. STREET ADDRESS <i>RFD#1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>HARFORD Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Milton M Cully Jr.</i>		4. DATE OF DEATH <i>FEBRUARY 25 1961</i>	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-23-1883</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Telegraph Operator</i>		11. BIRTH PLACE (County & State, or foreign country) <i>PENNA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S</i>		13. FATHER'S NAME <i>George Cully</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Strigel</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>216-09-8208</i>		17. INFORMANT <i>John W. Cully Jr., Perryville, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute Anterior Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (b) <i>Advanced arteriosclerotic cardiovascular disease.</i> DUE TO (c) cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Saccular Aneurysm - aorta bifurcation</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>FEB 11</i> , 19 <i>61</i> to <i>1961</i> , that (I) (we) last saw the deceased alive on <i>FEB 25</i> , 19 <i>61</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.H. Sadowsky</i> M.D.		22b. DATE SIGNED <i>2/25/61</i>	
22c. PHYSICIAN'S NAME (Type or print) <i>W.H. SADOWSKY</i>		22d. ADDRESS <i>504 Lewis St. Havre de Grace, Md.</i>	
23a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-28-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Marks Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Perryville, Md. Rural</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. A. Patterson & Son, Perryville, Md.</i>		25a. REC'D BY REGISTRAR <i>FEB 28 61</i> DATE	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krawitz</i>	

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1959

CERTIFICATE OF DEATH

01935

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u> c. LENGTH OF STAY IN 1b <u>8 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u> d. STREET ADDRESS <u>419 LODGE ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>OSCARA ADDIE DUTTON</u>		4. DATE OF DEATH FEB. 25 1961		5. SEX <u>F</u>			
6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 26, 1889</u>			
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Rollinville, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>FRED ALLISON</u>				14. MOTHER'S MAIDEN NAME <u>JULIA LA RUE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-32-3265</u>		17. INFORMANT <u>Mrs. Idella Wainwright, Havre de Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thromboses</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>arterio clotic heart disease</u> 3 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cerebral Pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>2/12/1961</u> Hour a.m. <u> </u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Havre de Grace</u> (County) <u>Harford</u> (State) <u>MD.</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>2/12/1961</u> to <u>2/25/1961</u> , that (I) (we) last saw the deceased alive on <u>2/25/1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas L. Wacklamer M.D.</u>				22b. DATE SIGNED FEB 25 1961			
22c. PHYSICIAN'S NAME (Type) <u>Thomas L. Wacklamer</u>				22d. ADDRESS <u>552 Lewis St.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-1-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem</u>			
23d. LOCATION (City, town or county) <u>Harford Co. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Stella J. Bullock, Havre de Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01936

1. PLACE OF DEATH o. COUNTY MARYLAND HARFORD				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CECIL ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVEY DE GRACE		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL				d. STREET ADDRESS 07X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle IDA Last FELTMAN				4. DATE OF DEATH Month FEB Day 3 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 472-01-7273D		17. INFORMANT Address Carl D. Feltman Rising Sun, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/5 to 2/3 , 19 61 , that (I) (we) last saw the deceased alive on 2/2 19 61 , and that death occurred at 4:50 PM from the causes and on the date stated above.							
22a. SIGNATURE Neil Taylor				22b. DATE SIGNED 2/3/61		22c. PHYSICIAN'S NAME (Type) Neil Taylor	
22d. ADDRESS Rising Sun, Md				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-7-1961		23c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		23d. LOCATION (City, town, or county) (State) Rising Sun, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Norman E. McMillen				25a. REC'D BY REGISTRAR DATE FEB 7 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



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Name of Person
Date of Birth
Place of Birth

Ann Arbor
Feb 10 1900
Michigan
U.S.A.

PRELIMINARY
STATE OF MICHIGAN
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
ANN ARBOR
FEB 10 1900
MICHIGAN
U.S.A.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is not known, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01957

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perryman</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>70 Mitchell Bro. Quarrying Co.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perryman</u> d. STREET ADDRESS <u>70 Mitchell Bro. Quarrying Co.</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph Fisher</u>		4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/1881</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quarrying Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.A.</u>	
13. FATHER'S NAME <u>George Fisher</u>			14. MOTHER'S MAIDEN NAME <u>Harriett Wilmore</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT <u>Olivia Staushury - Perryman, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D.		CHIEF MEDICAL EXAMINER <u>Bell Air</u>		DATE SIGNED <u>2-5-61</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer - MD</u>		DEPUTY MEDICAL EXAMINER <u></u>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union U.S. Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Aberdeen - Maryland</u>	
23. FUNERAL DIRECTOR <u>John F. Barving</u>				ADDRESS <u>Aberdeen - Maryland</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
				24b. REGISTRAR'S SIGNATURE			

DATE FEB 10 '61

1221

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01938

1962

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrods-Brace</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. STREET ADDRESS <u>Box 74</u>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Gabbert</u> Last <u>Gabbert</u>		4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1919</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Holbrook</u>		14. MOTHER'S MAIDEN NAME <u>Elva Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-22-4726</u>	
17. INFORMANT <u>Paul Gabbert, Husband</u>		Address <u>Port Deposit, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial Endocarditis</u> 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcohol & Chronic Passive Congestion of the Heart</u> DUE TO (c) <u>Chronic Passive Congestion of the Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1, 1961</u> , to <u>2-17</u> , 1961, that (I) (we) last saw the deceased alive on <u>2-17</u> , 1961, and that death occurred at <u>5:22</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>G.H. Richards Jr.</u>		22b. DATE SIGNED <u>3/12/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.H. Richards Jr.</u>		22d. ADDRESS <u>Port Deposit, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Removal & Burial</u>	<u>2-18-1961</u>	<u>Woodlawn Cemetery</u>	<u>Auto, West Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>		25a. REC'D BY REGISTRAR <u>Perryville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		DATE <u>FEB 20 '61</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

200

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1963

01939

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUGS DE GRACE</u> c. LENGTH OF STAY IN 1b <u>5 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CECIL</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Port Deposit</u> d. STREET ADDRESS <u>07X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Woodward</u> First <u>A</u> Middle <u>Gatchell</u> Last			4. DATE OF DEATH <u>FEBRUARY 16</u> 19 <u>61</u> Month Day Year				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Nov 26, 1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jeremiah Gatchell</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Adams</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO. <u>212-32-0633</u>		17. INFORMANT <u>Alice R. Gatchell, Port Deposit Rural, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Angine Pectoris</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> 19 <u>55</u> to <u>2-16</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-15</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.					
22a. SIGNATURE <u>G. H. Richards, Jr.</u> M.D.		22b. DATE SIGNED <u>2/16/61</u>		22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards, Jr.</u>			
22d. ADDRESS <u>Port Deposit, Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>2-19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Colona Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Perryville, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>FEB 20 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1963

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely lined in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01940

1964

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. LENGTH OF STAY IN 1b 2 HRS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL HOSP.				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE			
3. NAME OF DECEASED (Type or print) MARY A (nee Frazzitta) GENTRY				d. STREET ADDRESS 308 Wilson St.			
5. SEX FEMALE				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Mar. 1, 1905			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser				10b. KIND OF BUSINESS OR INDUSTRY Laundry			
11. BIRTHPLACE (County & State, or foreign country) Italy				12. CITIZEN OF WHAT COUNTRY U.S.A.,			
13. FATHER'S NAME Frank Albione				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-10-9917			
17. INFORMANT Thomas Gentry				Address Havre de Grace Md.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac Failure 425.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Chronic cardiac decompensation (c) Coronary thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-17 , 19 61 , to 2-17 , 19 61 , that (I) (we) last saw the deceased alive on 2-17 , 19 61 , and that death occurred at 11:45 M, from the causes and on the date stated above.							
22a. SIGNATURE E. J. Simon				22b. DATE SIGNED 2-17-61			
22c. PHYSICIAN'S NAME (Type) E. J. Simon				22d. ADDRESS HAVRE DE GRACE, Md.			
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE THEREOF Feb. 22, 1961			
23c. NAME OF CEMETERY OR CREMATORY Angel Hill				23d. LOCATION (City, town or county) (State) Havre de Grace, Harford, Md.,			
24. FUNERAL DIRECTOR'S SIGNATURE Edward L. Brown				25a. REC'D BY REGISTRAR DATE FEB 24 '61			
ADDRESS Abingdon, Md.,				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

I

M

(M)

(no. 111111)

Mar. 1, 1901

Monday

Friday

Unknown

Frank Albion

(1)

Thomas Gentry

12-10-1917

no

Have de Grace, Md.

Angel Hill

F. D. S. 1901

1-9-1917

Abington, Md.

Have de Grace, Maryland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1965

CERTIFICATE OF DEATH

Reg. Dist. No. 01941

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural * Street		c. LENGTH OF STAY IN 1b 57 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -Street	
		d. STREET ADDRESS 1	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VERNON Middle ELMER Last GRIER		4. DATE OF DEATH Month February Day 24 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 9, 1903
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR: Months 57 Days 57 Hours 57 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile setter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Street, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer L. Grier		14. MOTHER'S MAIDEN NAME Josephine Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-14-0038	
17. INFORMANT Miss Margie Grier, Balto. 13, Md.		Address 3821 Belair Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Failure 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cor Pulmonare DUE TO (c) Chronic Emphysema + Bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post operative - Cholecystectomy 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1960 , to Feb 24, 1961 , that I last saw the deceased alive on Feb 23, 1961 , and that death occurred at 7:30 M, from the causes and on the date stated above. ACTUAL SIGNATURE Joshua A. Hunt M.D. Joshua A. Hunt ADDRESS (Street, city or town, state) Delta Pa DATE SIGNED 2/29/61 PHYSICIAN'S NAME (Type) Joshua A. Hunt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27, 1961	
22c. NAME OF CEMETERY OR CREMATORY Deer Creek Meth.		22d. LOCATION (City, town, or county) (State) Forest Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins		24a. REC'D BY REGISTRAR DATE MAR 1 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1-54-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1966 CERTIFICATE OF DEATH

Reg. Dist. No.

01942

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Gunther		d. STREET ADDRESS Willoughby Beach	
4. DATE OF DEATH Month Feb. Day 22 Year 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1874
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,	
11. BIRTHPLACE (State or foreign country) Edgewood, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Frederick Gunther		14. MOTHER'S MAIDEN NAME Emka Behrends	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosa M. Gunther		Address Edgewood Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis heart disease 420.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1 , 19 59 , to 2-22 , 19 61 , that I last saw the deceased alive on 2-22 , 19 61 , and that death occurred at 11:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edgewood Md DATE SIGNED 2-20-61 ACTUAL SIGNATURE Fred O. Hodus M.D. Edgewood Md PHYSICIAN'S NAME (Type) Fred O. Hodus Edgewood Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 26, 1961	
22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Md.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard L. Thomas Jr		24a. REC'D BY REGISTRAR DATE FEB 28 '61	
ADDRESS Abingdon Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

1908

Age at Death

Place of Birth

Sex

Married

Occupation

Religion

Signature

Signature

Signature

Witness

Signature

Signature

Signature

Signature

Signature

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is not necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1961 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01943

1. PLACE OF DEATH e. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Churchville Road</u>				d. STREET ADDRESS <u>1 Churchville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Hackett</u> Last <u>Hackett</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11-1869</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Augusta Hinson</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs Evelyn Dorsey</u> Address <u>24 Churchville Road Bel Air, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V Disease</u> <u>422.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-16-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb 18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Methodist</u>	
22d. LOCATION (City, town, or country) <u>Joppa, Harford MD</u>				22e. REC'D BY REGISTRAR <u>Joseph J. Ladd</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur L. Hinson</u>	

100

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01944

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		d. STREET ADDRESS 550 ALLIANCE	
3. NAME OF DECEASED (Type or print) First ELIZA Middle J. Last HASKINS		4. DATE OF DEATH Month February Day 3 Year 1961	
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 2 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Richmond, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph Jones		14. MOTHER'S MAIDEN NAME Jane (No Record of last name)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Calvin Haskins, Haver de Grace, Md.		Address 550 Alliance St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Generalized Arteriosclerosis (c) Pulmonary Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 9, 1961 to Feb. 3, 1961 , that (I) (we) last saw the deceased alive on 3 Feb 1961 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE George T. Stansbury		22b. DATE SIGNED 2/4/61	
22c. PHYSICIAN'S NAME (Type) George T. Stansbury		22d. ADDRESS 569 Revolution St, Haver de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION (City, town, or county) (State) Aberdeen, Harford, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock		25a. REC'D BY REGISTRAR FEB 8 '61	
ADDRESS Haver de Grace, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

Page 4
TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1901

1

OFFICE OF THE REGISTRAR

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1969
CERTIFICATE OF DEATH

01945

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> c. LENGTH OF STAY in 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> d. STREET ADDRESS <u>83 N. Main</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael Joseph</u> First Middle Last		4. DATE OF DEATH <u>2</u> <u>5</u> <u>1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>NEW</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1961</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>12</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hipkins, Walter H.</u>		14. MOTHER'S MAIDEN NAME <u>Dolores A. Maloy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Walter H. Hipkins, Port Deposit, Md.</u>	
17. INFORMANT <u>Walter H. Hipkins, Port Deposit, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>754.5</u> IMMEDIATE CAUSE (a) <u>Congenital heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> , 19 <u>61</u> , to <u>2/5</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>61</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore H. Kaiser</u> 22c. PHYSICIAN'S NAME (Type) <u>Theodore H. Kaiser, M.D.</u>		22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Harre De Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-7-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Port Deposit, Md. Rural</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson</u> ADDRESS <u>Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1000

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1970

CERTIFICATE OF DEATH

01946

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BELAIR</u> d. STREET ADDRESS _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HANCOCK DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 DAYS</u>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>			
3. NAME OF DECEASED (Type or print) <u>Effie W Johnson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28 - 1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothes</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAJOR Willis</u>				14. MOTHER'S MAIDEN NAME <u>JULIA EDWARDS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-20-2711</u>		17. INFORMANT <u>Mrs Irene Billings</u> Address <u>Bel Air Md RD 2 Box 54 A</u>			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Intestinal distention</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Carcinomatous from stomach</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19.....; that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. K. Jones</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS _____			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Mar 1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) <u>Bel Air Harford Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway + Williams St. BEL Air, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>				_____			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1970

10/22-10/23
10/24-10/25
10/26-10/27
10/28-10/29
10/30-10/31

12

10/31-11/1
11/2-11/3
11/4-11/5
11/6-11/7
11/8-11/9
11/10-11/11
11/12-11/13
11/14-11/15
11/16-11/17
11/18-11/19
11/20-11/21
11/22-11/23
11/24-11/25
11/26-11/27
11/28-11/29
11/30-12/1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1971

CERTIFICATE OF DEATH

01947

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> c. LENGTH OF STAY IN 1b <u>33 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>554 Alliance Street</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> 24 d. STREET ADDRESS <u>554 Alliance St.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Mable J. Joyner</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 15, 1899</u> 61 yrs.		9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food Cannery</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Holly Hill So. Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Thomas Jenkins</u>						14. MOTHER'S MIDDEN NAME <u>Betty Oliver</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>210-03-2479</u>				17. INFORMANT Address <u>554 Alliance St.</u> <u>Mrs Frances Cromwell Harre de Grace, Md</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart disease = Cerebral Sclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>420.0</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-4</u> , 19 <u>61</u> , to <u>2-2</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-1</u> , 19 <u>61</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>George T. Stansbury, M.D.</u>								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2/4/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>								22d. ADDRESS <u>519 Revolution St. Harre de Grace, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/5/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>				23d. LOCATION (City, town or county) <u>Harre de Grace, Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Bullock</u>								ADDRESS <u>Harre de Grace, Md</u>				25a. REC'D BY REGISTRAR <u>FEB 8 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

1971

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1 2 M X I 0 1 BP VS A1S (4) 15M 10/57 TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be released by the hospital or attending physician, or by the funeral director, to the funeral director, who must file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1972 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No. 01948

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 S. Phila. Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHRISTIAN J. KALMBACKER		4. DATE OF DEATH February 15 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John George Kalmbacker		14. MOTHER'S MAIDEN NAME Barbara Anna Schantz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary L. Kalmbacker, Aberdeen, Md.		Address 232 S. Phila. B	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT DUE TO CEREBRAL THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1960 to February 1961 , that I last saw the deceased alive on Feb 13 1961 , and that death occurred at 4:00AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Andre Weiss		ADDRESS (Street, city or town, state) 114 W. Bel Air Ave.	
PHYSICIAN'S NAME (Type) Andre Weiss, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/61	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Tarring		ADDRESS Tarring Funeral Home, Aberdeen, Md.	
24a. REC'D BY REGISTRAR FEB 20 1961		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

CERTIFICATE OF DEATH

1933

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

Age at Death

Place of Birth

Married

Report

Signature

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1933

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1973

CERTIFICATE OF DEATH

Reg. Dist. No. 01949

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hopt.</u>				d. STREET ADDRESS <u>307 S. Union Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>H.</u> Middle <u>Kent</u> Last				4. DATE OF DEATH <u>Feb.</u> Month <u>3</u> Day <u>1961</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1st, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Meriden Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ballistician (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. A.P.C. and</u>			
13. FATHER'S NAME <u>Silas William Kent</u>				14. MOTHER'S MAIDEN NAME <u>Mary Chapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>War I.</u>				16. SOCIAL SECURITY NO. <u>Long Island, N.Y. 85 Windham Rd.</u>			
17. INFORMANT <u>Mrs. Sidney Grant, Rockville Center</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Gastric Intestinal Haemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypoproteinememia</u> (c) <u>Cirrhosis of Liver</u> INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>1 year</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1948</u> , 19 <u>61</u> to <u>2-3-1961</u> , that I last saw the deceased alive on <u>2-3-1961</u> , and that death occurred at <u>6:32 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.				ADDRESS (Street, city or town, state) <u>8 L. Ave St. Aberdeen, Md.</u> DATE SIGNED <u>2/3/61</u>			
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>2/3/1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Crematory</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> ADDRESS <u>Aberdeen, Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 7 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1974

Reg. Dist. No. 01950

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Street</u>			c. LENGTH OF STAY IN 1b <u>60 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Street</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>HUGH</u> Middle <u>M.</u> Last <u>LAIRD</u>				4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1961</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1778</u>		9. AGE (In years last birthday) <u>82</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Agri.</u>		11. BIRTHPLACE (State or foreign country) <u>Gatchelville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Hugh M. Laird</u>				14. MOTHER'S MAIDEN NAME <u>Mary Boyd</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-36-0755</u>		17. INFORMANT Address <u>Mrs. May J. Laird, Street, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>3 wk</u> <u>3 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept</u> <u>1959</u> , to <u>10 Feb</u> <u>1961</u> , that I last saw the deceased alive on <u>10 February 61</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Whiteford, Maryland</u> DATE SIGNED <u>12 Feb 61</u>											
ACTUAL SIGNATURE <u>Edwin W. Whiteford Jr. M.D.</u> M.D. <u>Whiteford, Maryland</u>											
PHYSICIAN'S NAME (Type) <u>Edwin W. Whiteford Jr., M.D.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>2-14-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius</u>			22d. LOCATION (City, town, or county) (State) <u>Hickory, Harford Co., Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>				ADDRESS <u>Delta, Penna.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hance</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1954

MINOR

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		M		35		JAN 5, 1919		MOBILE, ALABAMA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
HEART DISEASE		SUICIDE		HOME		JAN 4, 1968		10:00 PM	
IMMEDIATE CAUSE		UNDERLYING CAUSE		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF PHYSICIAN	
MYOCARDIAL INFARCTION		CORONARY ARTERY DISEASE		JAN 4, 1968		BALTIMORE, MD		JAMES EARL RAY	
DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF PHYSICIAN		DATE OF DEATH		TIME OF DEATH	
JAN 4, 1968		BALTIMORE, MD		JAMES EARL RAY		JAN 4, 1968		10:00 PM	

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		M		35		JAN 5, 1919		MOBILE, ALABAMA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
HEART DISEASE		SUICIDE		HOME		JAN 4, 1968		10:00 PM	
IMMEDIATE CAUSE		UNDERLYING CAUSE		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF PHYSICIAN	
MYOCARDIAL INFARCTION		CORONARY ARTERY DISEASE		JAN 4, 1968		BALTIMORE, MD		JAMES EARL RAY	
DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF PHYSICIAN		DATE OF DEATH		TIME OF DEATH	
JAN 4, 1968		BALTIMORE, MD		JAMES EARL RAY		JAN 4, 1968		10:00 PM	

X

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1975

CERTIFICATE OF DEATH

Reg. Dist. No.

01951

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>123 D. Union Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>William G. Lippel</u>		4. DATE OF DEATH <u>2/4/61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/1896</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert Lippel</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mosman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mary L. Lippel</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>suble</u> (c) <u>suble</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-4</u> , 19 <u>61</u> , to <u>2-4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-3</u> , 19 <u>61</u> , and that death occurred at <u>2:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Simon</u>		ADDRESS (Street, city or town, state) <u>200 S. UNION AVE</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>		DATE SIGNED <u>HAURE DE GRACE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/7/61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony J. P. Harford Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>FEB 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

CERTIFICATE OF DEATH

1952

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF CEMETERY

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CLERGYMAN

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE
 BURIAL AND CREMATION LAWS OF THE STATE OF
 MARYLAND. IT IS NOT VALID FOR ANY OTHER
 PURPOSES. IT IS THE DUTY OF THE CLERGYMAN
 TO SIGN THIS CERTIFICATE AND TO SIGN THE
 BURIAL OR CREMATION RECORD.

ISSUED BY
 STATE OF MARYLAND

1976.

CERTIFICATE OF DEATH

Reg. Dist. No. 01952

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>81 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1 Rural</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Henry</u> Middle <u>Magness</u> Last				4. DATE OF DEATH <u>Feb.</u> Month <u>20</u> Day <u>1961</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 20, 1879</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Bel Air Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Magness</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Demoss Bel Air Md</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Walter Magness</u> Address <u>Benson Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA AND RENAL SHUT DOWN</u> <u>422</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DIS.</u> <u>over 4 yrs</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BPH</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 22, 1957</u> to <u>FEB 20, 1961</u> , that I last saw the deceased alive on <u>FEB 20, 1961</u> , and that death occurred at <u>10:30AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>307 HICKORY AVE</u> DATE SIGNED <u>FEB 23, 61</u>							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.				PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN M.D. BEL AIR, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb-23, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W H Archer</u> ADDRESS <u>Benson Md</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1/12
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before Admission) a. STATE NEW YORK b. COUNTY LONG ISLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE DOA		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 306 CRABAPPLE Rd, MANHASSET	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PASSENGER CAR, PENNA. R.R. STA.		d. STREET ADDRESS 69X2	
3. NAME OF DECEASED (Type or print) First Middle Last LEO KENNETH MAYER		4. DATE OF DEATH Month Day Year FEBRUARY 5 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 13, 1899
9. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10b. KIND OF BUSINESS OR INDUSTRY ECONOMIST	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL MAYER		14. MOTHER'S MAIDEN NAME ADELE KAUFMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNK		16. SOCIAL SECURITY NO. UNK	
17. INFORMANT JOYCE M. GOLDBERG, GLEN COVE, N.Y.		Address 37 OAK LANE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY INSUFFICIENCY (c) 6 1/2 YRS DUE TO (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH INSTANT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip W. Heuman M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE FEB 7 '61	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1978

CERTIFICATE OF DEATH

01954

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVERLE GRACE 10 MIN.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AIKEN AVE, PERRYVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL HOSPITAL				d. STREET ADDRESS 07X-2			
3. NAME OF DECEASED (Type or print) HARRY S. MCMULLEN				4. DATE OF DEATH FEBRUARY 24 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 29, 1902	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY			
11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME ARTHUR MCMULLEN				14. MOTHER'S MAIDEN NAME Marion SHARPLESS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW II				16. SOCIAL SECURITY NO. 212-30-3516			
17. INFORMANT Elva D. McMullen, Perryville, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 12hr DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at 3:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Clarence I. Benson M.D. Gerald C. Palmer M.D. Deputy				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Gerald C. Palmer				22d. ADDRESS Port Deposit, Md. Bel Air, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY		23d. LOCATION (City, town or county) (State)	
Burial		2-26-1961		Harford County, Md.		Principio Furnace, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR DATE FEB 27 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Handwritten signature and text at the bottom of the page, including the name "J. B. [illegible]" and "J. B. [illegible]".

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the pages are not used, they should be retained for your files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1979 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01955

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> c. LENGTH OF STAY IN 1b <u>Edgewood</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wiloughby Beach Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> d. STREET ADDRESS <u>Wiloughby Beach Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Mercer</u> Middle <u></u> Last <u></u>		4. DATE OF DEATH <u>February 8</u> Month <u>1961</u> Day <u>8</u> Year <u>1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 28, 1979</u> 81 yrs.		9. AGE (In years last birthday) <u>81</u> Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>578-16-2598</u>		17. INFORMANT <u>Harford Co., Welfare Board, Bel Air, Md.,</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>				19. INTERVAL BETWEEN ONSET AND DEATH <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-8-61</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ADDRESS <u>Abingdon, Md.,</u>		22a. BURIAL CREMATION, REMOVAL (Specify) <u>3-2-61</u>		22b. DATE THEREOF <u>3-2-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>W. of Md. Med. School</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>		23. FUNERAL DIRECTOR <u>Howard E. McGowan</u>		24a. REC'D BY REGISTRAR <u>Abingdon, Md.,</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		DATE <u>MAR 6 '61</u>					

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1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Aberdeen Proving Ground, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle JAMES Last MILLS		4. DATE OF DEATH Month February Day 2 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 9, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier-M/Sgt (Retired)		10b. KIND OF BUSINESS OR INDUSTRY US Army Retired	9. AGE (In years last birthday) 74 yrs.
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry James Mills (212-26-2984)		14. MOTHER'S MAIDEN NAME Elizabeth Margaret Curtis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 30 Oct 1910 212-26-2984	
17. INFORMANT Grace May Mills (Wife)		Address Same as item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 13 Sep 60
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____	Month _____ Day _____ Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____
21. I certify that at (this hospital) attended the deceased from September 13 60 to February 2, 19 61 that at (we) last saw the deceased alive on February 2 19 61 and that death occurred at 7:00PM am the causes and on the date stated above.			
22a. SIGNATURE Mark Eisenstein		22b. DATE 2 Feb 61	
22c. PHYSICIAN'S NAME (Type) MARK EISENSTEIN Capt MC		22d. ADDRESS US Army Hospital Aberdeen Proving Ground, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Feb. 7, 1961	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Post Cemetery	23d. LOCATION (City, town, or county) (State) Army Chemical Center Md.,
24. FUNERAL DIRECTOR'S SIGNATURE Neward H. Upchurch		25a. REC'D BY REGISTRAR DATE FEB 8 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

CERTIFICATE OF DEATH

1967

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

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11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]
15. Registrar's signature: [illegible]
16. Registrar's name: [illegible]
17. Registrar's title: [illegible]
18. Registrar's address: [illegible]
19. Registrar's telephone: [illegible]
20. Registrar's fax: [illegible]

21. Registrar's stamp: [illegible]
22. Registrar's date: [illegible]
23. Registrar's time: [illegible]
24. Registrar's location: [illegible]
25. Registrar's contact information: [illegible]
26. Registrar's signature: [illegible]
27. Registrar's name: [illegible]
28. Registrar's title: [illegible]
29. Registrar's address: [illegible]
30. Registrar's telephone: [illegible]
31. Registrar's fax: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **01957**

1981

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. LENGTH OF STAY IN 1b 30 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Joppa	
3. NAME OF DECEASED (Type or print) First John Middle L. Last Payne		4. DATE OF DEATH Month Feb. Day 15 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY U.S.A.,	
13. FATHER'S NAME Levin Payne		14. MOTHER'S MAIDEN NAME Sarah Henderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-14-4832	
17. INFORMANT Virginia B. Payne,		Address Joppa, Md.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia- Gangrene right arm from Thrombosis 4-22-1 DUE TO Brachial artery. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Cardio Vascular Disease. DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 3 , 19 57 , to Feb. 14 , 19 61 , that I last saw the deceased alive on Feb. 13 , 19 61 , and that death occurred at 3:20 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED			
ACTUAL SIGNATURE Willard P. Hudson M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Willard P. Hudson M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 17, 1961	22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran	22d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McConis Jr.		ADDRESS Abingdon, Md.,	24a. REC'D BY REGISTRAR FEB 20 '61
			24b. REGISTRAR'S SIGNATURE Arthur S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be returned to the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1982 CERTIFICATE OF DEATH

01958

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Harford</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Federal Hill</u> | | LENGTH OF STAY (in this place)
<u>63 years</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Rural Rocks</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location)
<u>Federal Hill</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
<u>Dora</u> <u>Faidley</u> <u>Phillips</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>FEB.</u> <u>28</u> <u>1961</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Widowed</u> | | 8. DATE OF BIRTH
<u>Dec. 1, 1865</u> | |
| 9. AGE last birthday
<u>95</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Gallatin, Tenn.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Charles F. Faidley</u> | | 14. MOTHER'S MAIDEN NAME
<u>Susanna Fothergill</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-38-9085</u> | | 17. INFORMANT & ADDRESS
<u>Mrs. Robert Foard</u> <u>Rocks, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 601X IMMEDIATE CAUSE (A) <u>Nyctomphrosis, Bilateral</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 years</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.
<u>Arteriosclerotic Cardiovascular Disease</u> | | | | <u>15 years</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)
M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>11/25/</u>, 19<u>57</u>, to <u>2/27/</u>, 19<u>61</u>, that I last saw the deceased alive on <u>2/27/</u>, 19<u>61</u>, and that death occurred at <u>10:30 P.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Robert Barthel</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u> | | | |
| DATE SIGNED <u>2/29/61</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>3/2/1961</u> | | NAME OF CEMETERY OR CREMATORY
<u>Jarrettsville</u> | | LOCATION (City, town, or county)
<u>Jarrettsville, Md.</u> | |
| 24. REC'D BY REGISTRAR
DATE <u>MAR 3 '61</u> | | REGISTRAR'S SIGNATURE
<u>Charles E. Fust</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles E. Fust</u> <u>Jarrettsville, Md.</u> | | | |

1985

DATE: 10/10/2001

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1983

Item 9 Film 6250 2-9-61 et

01959

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Forest Hill | | c. LENGTH OF STAY IN 1b
55 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle Barclay Last PHILLIPS | | 4. DATE OF DEATH
Month February Day 4 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 3, 1884 |
| 9. AGE (In years last birthday)
77 1/2 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer owner | | 10b. KIND OF BUSINESS OR INDUSTRY
Gen. Farming | |
| 11. BIRTHPLACE (State or foreign country)
Nottingham, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
F. Harvey Phillips | | 14. MOTHER'S MAIDEN NAME
Catherine Hetherington | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Miss. Kathleen Phillips | | Address
Forest Hill Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Ch. Cardio-vascular Disease
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
?
? | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 1958 to Feb. 4, 1961 , that (I) (we) last saw the deceased alive on Feb. 1, 1961 , and that death occurred at 2:30 , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Willard P. Hudson | | 22b. DATE SIGNED
2/4/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Willard P. Hudson, M.D. | | 22d. ADDRESS
Forest Hill, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/7/1961 | 23c. NAME OF CEMETERY OR CREMATORY
Old Brick Baptist | 23d. LOCATION (City, town, or county) (State)
Jarrettsville Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Rutz | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Howard | |
| ADDRESS
Jarrettsville Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 7 '61 | |

MEDICAL CERTIFICATION

1983

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| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Harre-de-Grace</u> | | c. LENGTH OF STAY in 1b
<u>12 hrs.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Darlington</u> | | d. STREET ADDRESS
<u>Box 105</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Harford Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Donald L.</u> Middle <u>Presberry</u> Last <u>Presberry</u> | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>9</u> Year <u>1961</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1/28/61</u> | 9. AGE (In years last birthday)
<u>12</u> yrs. | IF UNDER 1 YEAR
Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Baby</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Baby</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>Howard C. Presberry</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Doris C. Tolliver</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Howard C Presberry Darlington Md.</u>
Address <u>Box 105</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
603X DUE TO <u>Renal vein Thrombosis, bilateral</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Diabetic Mellitus</u>
(a), stating the underlying cause last. DUE TO (c) <u>—</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 28</u> , 19 <u>61</u> , to <u>Feb 9</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb 9</u> , 19 <u>61</u> , and that death occurred at <u>5:30</u> P.M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>George T. Stansbury</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2/11/61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>George T. Stansbury</u> | | | | 22d. ADDRESS
<u>569 Revolution St. Harre de Grace, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/11/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Berkley Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Darlington Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Elmer E. Bullough</u> | | | | 25a. REC'D BY REGISTRAR
<u>—</u> | | 25b. REGISTRAR'S SIGNATURE
<u>—</u> | |
| ADDRESS
<u>Harre de Grace</u> | | | | DATE
<u>FEB 15 '61</u> | | | |

2071266XV6

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed by a physician after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1084

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are not true, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|--|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 1985 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| Item 9 Film 3281 2-16-61 et 01961 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fountain Green Road</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Harford</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>
d. STREET ADDRESS <u>R.D. #2 / Fountain Green Road</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Hall E Rogers</u> | | | | | | 4. DATE OF DEATH <u>February 4 1961</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 21, 1903</u> | | 9. AGE (In years last birthday) <u>57</u> yrs. | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner (Ret.)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Merchandise</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Wallace Rogers</u> | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. <u>217-01-3959</u> | | 17. INFORMANT <u>Charles W. Rogers</u> | | | | Address <u>110 Baltimore St Aberdeen Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>25W Cerebrum</u>
DUE TO <u>976X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976X</u>
DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>2-27-61</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Belt Air</u> (County) <u>Harford</u> (State) <u>MD</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> (Belt Air MD) | | | | | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-4-61</u> | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>2/11/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cemetery</u> | | 22d. LOCATION (City, town, or country) (State) <u>R.D. 2, Aberdeen, Md.</u> | | | |
| 23. FUNERAL DIRECTOR <u>John G. Tarring</u> Tarring Funeral Home Aberdeen, Md. | | | | | | 24a. REC'D BY REGISTRAR <u>FEB 7 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

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Page 4
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1986
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01962

| | | | | | | | |
|--|--|---------------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen Proving Ground | | | | c. LENGTH OF STAY IN 1b
22 hours | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Army Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Colora | | | |
| 3. NAME OF DECEASED (Type or print)
First ELSENA Middle FAYE Last SHIRES | | | | 4. DATE OF DEATH
Month February Day 15 Year 1961 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 14, 1961 | |
| 9. AGE (In years lost birthday) yrs. | | 10. AGE (In years lost birthday) yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
22 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
N/A | | | | 10b. KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
WILLIAM FAY SHIRES | | | | 14. MOTHER'S MAIDEN NAME
RUTH ELSIE BLAKELEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
N/A | | | | 16. SOCIAL SECURITY NO.
N/A | | | |
| 17. INFORMANT
Mrs. Ruth Shires (Mother) | | | | Address
Colora, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity, severe
776X DUE TO (Approx 6 months gestation)
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last, (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (H) (this hospital) attended the deceased from 14 Feb 1961 to 15 Feb 1961 , that (I) (we) last saw the deceased alive on 15 Feb 1961 and that death occurred at 9:25 P , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Mark Eisenstein M.D. | | | | 22b. DATE SIGNED
February 15, 1961 | | | |
| 22c. PHYSICIAN'S NAME (Type)
MARK EISENSTEIN, Captain, MC | | | | 22d. ADDRESS
U.S. ARMY HOSPITAL
Aberdeen Proving Ground, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
2/18/60 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
West Nottingham | | | | 23d. LOCATION (City, town, or county) (State)
Colora Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Thomas E. M. Miller Rising Sun, Md. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 20 '61 | | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. H... | | | | | | | |

MINISTRY OF HEALTH
CERTIFICATE OF DEATH

1966

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1987

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01963

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|---|---------------------------|---|-----------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen (Rural) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen (Rural) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
R.D. #2, | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle M. Last SIMMONS | | | | 4. DATE OF DEATH
Month February Day 11 Year 19 61 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 29, 1880 | 9. AGE (In years last birthday)
80 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic (Ret.) | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Ord. Dept. U.S. Govt. | | 11. BIRTHPLACE (State or foreign country)
North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
Henry Simmons | | | |
| 14. MOTHER'S MAIDEN NAME
Sarah Hanks | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
T. Cordie Simmons, Address R.D. #1 Aberdeen, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure and
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Small Cerebrovascular Accidents 4 yrs
(c) Generalized Atherosclerosis 10 yrs | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 mos |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. m. Month, Day, Year p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from June 12, 1950, to Feb 11, 1961, that I last saw the deceased alive on Feb 8, 1961, and that death occurred at 9:50 AM from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Dudley Phillips, M.D. | | | | ADDRESS (Street, city or town, state)
Darlington, Md. | | | |
| PHYSICIAN'S NAME (Type)
Dudley Phillips, M.D. | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/14/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | 22d. LOCATION (City, town, or county) (State)
R.D. Bel Air, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John F. Tarring | | | | 24a. REC'D BY REGISTRAR
DATE FEB 15 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

CERTIFICATE OF DEATH

1942

44-10-10

| | | | |
|----------------------|--|---------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES H. HARRIS | | JANUARY 15, 1942 | |
| AGE | | SEX | |
| 65 | | Male | |
| RACE | | RELIGION | |
| White | | Roman Catholic | |
| BIRTH DATE | | BIRTH PLACE | |
| JANUARY 1, 1877 | | BALTIMORE, MARYLAND | |
| MARRIAGE DATE | | MARRIAGE PLACE | |
| JANUARY 1, 1900 | | BALTIMORE, MARYLAND | |
| OCCUPATION | | CAUSE OF DEATH | |
| Retired | | Heart Disease | |
| PREVIOUS ILLNESS | | PLACE OF DEATH | |
| None | | Home | |
| DATE OF INTERMENT | | PLACE OF INTERMENT | |
| JANUARY 17, 1942 | | BALTIMORE, MARYLAND | |
| NAME OF FUNERAL HOME | | NAME OF MINISTER | |
| None | | None | |
| NAME OF PHYSICIAN | | NAME OF CORONER | |
| None | | None | |
| NAME OF WITNESSES | | NAME OF REGISTRAR | |
| None | | None | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1988

CERTIFICATE OF DEATH

Reg. Dist. No. 01964

| | | | | | | | | |
|---|--|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - FOREST HILL</u>
c. LENGTH OF STAY IN 1b <u>3 years</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WALTER'S MILL ROAD</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - FOREST HILL</u>
d. STREET ADDRESS <u>WALTER'S MILL ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>LESTER</u> Last <u>SMITH</u>
4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>8</u> Year <u>1961</u> | | | | 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH <u>AUGUST 24, 1891</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u> | | 11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Lee SMITH</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELLEN JOHNSON</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>236-07-1159</u> | | 17. INFORMANT Address <u>Mrs. Lytha Smith (wife) FOREST HILL, MD.</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Congestive heart failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>6 years</u>
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOPNEUMONIA, recurrent</u> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>September 25, 1954</u> , to <u>February 8, 1961</u> , that I last saw the deceased alive on <u>February 7, 1961</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE <u>Paul S. Stonesifer Jr.</u> M.D. <u>115 Fulford Ave</u> | | | | DATE SIGNED <u>2/8/61</u> | | | | |
| PHYSICIAN'S NAME (Type) <u>PAUL S. STONESIFER JR.</u> | | | | <u>Bel Air, MD.</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Feb. 11, 1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Md.,</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs Jr.</u> ADDRESS <u>Abingdon, Md.,</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>William S. Thane</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1989
CERTIFICATE OF DEATH

01965

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Harre-de-Grace</u> | | c. LENGTH OF STAY IN lb
<u>2 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Harford Memorial Hospital</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Aberdeen</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Lester Louis Smith</u> | | d. STREET ADDRESS
<u>220 Schmechel St</u> | |
| 5. SEX
<u>Male</u> | | 4. DATE OF DEATH
Month <u>2</u> Day <u>12</u> Year <u>1961</u> | |
| 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>2-10-61</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Infant</u> | | 9. AGE (In years last birthday)
IF UNDER 1 YEAR: Months <u>2</u> Days <u>7</u> Hours <u>—</u> Min. <u>—</u>
IF UNDER 24 HRS. <u>2</u> 1961 | |
| 11b. KIND OF BUSINESS OR INDUSTRY
<u>Infant</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | | 13. FATHER'S NAME
<u>Lester Smith</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Helen Snyder</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Lester Louis Smith Sr. 220 Schmechel St.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic failure</u>
756.2 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Congenital atresia bile ducts</u>
(c) <u>Maldevelopment, congenital</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>none</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hours.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>—</u> | |
| 20c. TIME OF INJURY
Hour e.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> 19 <u>61</u> to <u>2/12</u> 19 <u>61</u> , that (I) (yes) last saw the deceased alive on <u>Feb. 12, 1961</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>William M. Lee</u> M.D. | | 22b. DATE SIGNED
<u>2/13/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/14/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Bel Air Memorial Gds.</u> | | 23d. LOCATION (City, town or county) (State)
<u>Bel Air Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John G. Tarring - Aberdeen, Maryland.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 15 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1966

| | | | | | |
|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Haryford</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>street</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Doyle Road</u> | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Haryford</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>street</u>
d. STREET ADDRESS <u>Doyle Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Maisha Darlene Teague</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>6</u> Year <u>1961</u> | | 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JAN. 25, 1961</u> | |
| 9. AGE (In years last birthday) <u>12</u> yrs. 10. BIRTHPLACE (State or foreign country) <u>HAVER DE GRACE, MD.</u> | | 11. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>CURTIS TEAGUE</u> | | 14. MOTHER'S MAIDEN NAME <u>KATHRYN MAINE</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u> | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>CURTIS TEAGUE, STREET, MD.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO <u>776X</u>
Conditions, if any, which gave rise to immediate cause (b) <u>—</u>
DUE TO <u>—</u>
(c) <u>—</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year <u>19</u> | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <u>Bea Air, MD</u> | | DATE SIGNED <u>2-6-61</u> | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>2-8-1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>EMORY</u> | |
| 22d. LOCATION (City, town, or county) <u>STREET, MD.</u> | | 24a. REC'D BY REGISTRAR <u>John H. Harkins, Delta, Pa.</u> | | | |
| 24b. REGISTRAR'S SIGNATURE | | 24c. DATE <u>FEB 8 '61</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, giving the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1950

| | | | |
|---|--|---|--|
| NAME OF DECEASED
[Faint handwritten name] | | SEX
[Faint handwritten sex] | |
| AGE
[Faint handwritten age] | | DATE OF BIRTH
[Faint handwritten date] | |
| PLACE OF BIRTH
[Faint handwritten place] | | OCCUPATION
[Faint handwritten occupation] | |
| MARITAL STATUS
[Faint handwritten status] | | CAUSE OF DEATH
[Faint handwritten cause] | |
| MANNER OF DEATH
[Faint handwritten manner] | | SIGNATURE OF EXAMINER
[Faint handwritten signature] | |
| DATE OF EXAMINATION
[Faint handwritten date] | | TIME OF EXAMINATION
[Faint handwritten time] | |
| PLACE OF EXAMINATION
[Faint handwritten place] | | SIGNATURE OF WITNESS
[Faint handwritten signature] | |
| DATE OF DEATH
[Faint handwritten date] | | TIME OF DEATH
[Faint handwritten time] | |
| PLACE OF DEATH
[Faint handwritten place] | | SIGNATURE OF DECEASED
[Faint handwritten signature] | |
| DATE OF INTERMENT
[Faint handwritten date] | | TIME OF INTERMENT
[Faint handwritten time] | |
| PLACE OF INTERMENT
[Faint handwritten place] | | SIGNATURE OF INTERMENT
[Faint handwritten signature] | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01967

| | | | | | | | |
|---|---------------------------|--|-----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Bel Air</u> | | c. LENGTH OF STAY IN 1b
<u>40 years</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Bel Air</u> <u>32</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>122 Alliceanne St</u> | | | | d. STREET ADDRESS
<u>122 Alliceanne St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Ella</u> Middle <u>Wright</u> Last <u>Thomas</u> | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>15</u> Year <u>1961</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5-3-76</u> | 9. AGE (In years last birthday) <u>84</u> yrs. | IF UNDER 1 YEAR
Months <u>84</u> Days <u>0</u> | IF UNDER 24 HRS.
Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>domestic</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown Wright</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>1</u> | | 17. INFORMANT <u>West Thomas</u> Address <u>Bel Air MD RD 3 Box 322 A</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hemiplegia</u>
DUE TO <u>352X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) <u></u>
DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u></u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> | | | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-15-61</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Feb 17/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hendon's Hill</u> | | 22d. LOCATION (City, town, or country) (State)
<u>Bel Air Harford MD</u> | |
| 23. FUNERAL DIRECTOR
<u>Joseph H. Lott</u> ADDRESS <u>Bel Air MD</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 17 '61</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Thomas</u> | |

MEDICAL CERTIFICATION

THE STATE
DEPARTMENT

1000

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1000

1

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01968

1992

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Havre de Grace (Rural) | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Havre de Grace (Rural) | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
R.D. Livers Farm | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
JAMES H. THOMPSON | | | 4. DATE OF DEATH
Month February Day 22 Year 19 61 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
Oct. 27, 1881 | | 9. AGE (In years last birthday)
79 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Bto. R.R. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
William H. Thompson | | | 14. MOTHER'S MAIDEN NAME
Susie Culbert | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
214/14/4937 | | 17. INFORMANT
Address R.D.
Clem Thompson, Havre de Grace, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(c), stating the underlying cause lost. DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Gerald C. Palmer | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, W. | | DATE SIGNED
2-22-61 | |
| EXAMINER'S NAME (Type)
Gerald C. Palmer, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
2/24/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Greenwood Cemetery | |
| 22d. LOCATION (City, town, or county) (State)
Balto. Maryland | | 24a. REC'D BY REGISTRAR
DATE FEB 27 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Knead | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Darling - Aberdeen Maryland | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1993

CERTIFICATE OF DEATH

Reg. Dist. No. **01969**

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> <u>Maryland</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <u>Cabington</u>
c. LENGTH OF STAY IN 1b <u>70 yrs.</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabington</u>
d. STREET ADDRESS _____
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Millard E. Tydings</u> First Middle Last | | | | 4. DATE OF DEATH <u>2/9/61</u> Month Day Year | | | | | | | | | | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>4/6/1890</u> | | 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer U.S. Navy Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Harford, Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Millard F. Tydings</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary O'Neill</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | | | 17. INFORMANT <u>Eleanor D. Tydings, Cabington, Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Circulatory Failure</u>
DUE TO <u>162.1</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia, left lower lobe</u>
DUE TO (c) <u>Bronchogenic Carcinoma</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>12 hours</u>
<u>5 days</u>
<u>7 months</u> | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I attended the deceased from <u>2-4-</u> <u>1961</u> , to <u>2-9-</u> <u>1961</u> , that I last saw the deceased alive on <u>2-9-</u> <u>1961</u> , and that death occurred at <u>5:30 P.</u> M., from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>Peter P. Rodman, M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>8 Low St. Aberdeen, Md.</u> | | | | DATE SIGNED
<u>2-11-61</u> | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type)
<u>Peter P. Rodman M.D.</u> | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>2/12/61</u> | | | | 22b. DATE THEREOF | | | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Angel Hill</u> | | | | 22d. LOCATION (City, town, or county) (State)
<u>Harford County Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James J. Du. Harford County, Md.</u> | | | | | | | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 14 '61</u> | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

MAY BE RELIED ON BY HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01970

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Warrington Rhd.</u>
c. LENGTH OF STAY IN b. <u>10</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <u>Md</u>
b. COUNTY <u>Harford</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Warrington R. H.</u>
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>David E Gallace</u>
First Middle Last | | 4. DATE OF DEATH <u>Feb 23 1961</u>
Month Day Year | |
| 5. SEX <u>Male</u>
6. COLOR OR RACE <u>Colored</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 20 1906</u>
Month Day Year | |
| 9. AGE (In years last birthday) <u>54</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer Ignator</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co Md U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 9. AGE (In years last birthday) <u>54</u>
IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. Months Days Hours Min. | |
| 13. FATHER'S NAME <u>Joseph Gallace</u>
14. MOTHER'S MAIDEN NAME <u>Elizabeth Gallace</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>218-28-6605</u>
17. INFORMANT <u>Elizabeth Gallace</u>
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>443X</u>
(c) <u>Hypertensive-Arteriosclerotic Heart disease</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Pneumonitis with Poss. Pulmonary Neoplasm</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 19 <u>60</u> , to <u>2/23</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>61</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>George T. Stansbury, M.D.</u>
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> | | 22b. DATE SIGNED <u>2/27/61</u>
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <u>569 Revolution St. Havre de Grace, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 28, 1961</u>
23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedars</u>
23d. LOCATION (City, town or county) (State) <u>Harford Co, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H & Bailey</u>
ADDRESS <u>Warrington Rd</u> | | 25a. REC'D BY REGISTRAR <u>MAR 3 '61</u>
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | |

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 JOM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1995

CERTIFICATE OF DEATH

Reg. Dist. No. 01971

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Md</u> | | COUNTY <u>Harford</u> | |
| CITY OR TOWN <u>Bel Air Rural</u>
(If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY OR TOWN <u>Bel Air Rural</u>
(If outside corporate limits, write RURAL and give nearest town) | | STREET ADDRESS (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nursing Home</u> | | | | STREET ADDRESS | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>Bessie Lee Walters</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>February 26, 1961</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Jan. 3, 1880</u> | 9. AGE last birthday <u>81</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Walters Nursing Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Harford Co Md</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>James Temple</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Corilla Whitaker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-34-4062</u> | | 17. INFORMANT & ADDRESS <u>Edward Walter Bickel M.</u> | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 4226 IMMEDIATE CAUSE (A) <u>Uremia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Cardio-vascular Disease</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>January</u> , 1956, to <u>Feb. 26</u> , 1961, that I last saw the deceased alive on <u>Feb. 25</u> , 1961, and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Willard P. Hudson</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>Feb. 26, 1961</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF <u>March 1, 1961</u> | | NAME OF CEMETERY OR CREMATORY <u>Mt Taber</u> | | LOCATION (City, town, or county) (State) <u>Harford Co Md</u> | |
| 24. REC'D BY REGISTRAR <u>W. Bailey</u> | | REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Bailey</u> | | ADDRESS <u>Harlington</u> | |
| DATE <u>Feb 3 '61</u> | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01972

1996

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|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u> | | c. LENGTH OF STAY IN 1b <u>37 DAYS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>M</u> Last <u>WARFIELD</u> | | 4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>6</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 9th 1893</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u> Hours <u>1</u> Min. | 11. IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Smith</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214-12-0208</u> | |
| 17. INFORMANT <u>W. Douglas E. Stansbury (Son)</u> | | Address <u>Aberdeen</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
260X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u>
DUE TO
(c) <u>Hypertensive Cardio renal Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> 19 <u>60</u> , to <u>2/6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 6 1961</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>George T. Stansbury</u> | | 22b. DATE SIGNED <u>2/7/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> | | 22d. ADDRESS <u>569 Revolution St. Haver de Grace, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>2/10/1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Union W. E. Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Aberdeen, Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Barry - Aberdeen, Md.</u> | | 25a. REC'D BY REGISTRAR <u>Chilwe S. Evans</u> | |
| DATE <u>FEB 10 '61</u> | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1988

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1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Date of birth: [illegible]
4. Place of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Manner of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1997

CERTIFICATE OF DEATH

Reg. Dist. No. 01973

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Aberdeen</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Aberdeen</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>FD1 Box 220</u> | | d. STREET ADDRESS
<u>FD1 Box 220</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>VERNON</u> Middle <u>Armsong</u> Last <u>WOODS</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>9</u> Year <u>1961</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10/31/08</u> |
| 9. AGE (In years lost birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired US Navy</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Wyoming</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>U. S. A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Samuel Woods</u> | | 14. MOTHER'S MAIDEN NAME
<u>Bertha Bennett</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>Yes 23 yrs</u> | | 16. SOCIAL SECURITY NO.
Address <u>Hospital Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>
DUE TO (b) <u>AURICULAR Fibrillation</u>
DUE TO (c) <u>PULMONARY Fibrosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>APRIL 22, 1960</u> , to <u>Feb 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 6</u> , 19 <u>61</u> , and that death occurred at <u>3:45 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Leonard Niesenbaum</u> | | ADDRESS (Street, city or town, state)
<u>USNTE Bainbridge Md.</u> | |
| PHYSICIAN'S NAME (Type)
<u>LEONARD NIESENBAUM</u> | | DATE SIGNED
<u>10 Feb 61</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/11/1961</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Bel Air Memorial Gardens</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Bel Air, Harford Co Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John F. Garring</u> | | 24a. REC'D BY REGISTRAR
ADDRESS <u>Aberdeen - Maryland</u>
DATE <u>FEB 14 '61</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Evans</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

